TRFT Library & Knowledge Service

A library & knowledge service for all NHS staff in Rotherham

Knowledge @lert: Patient safety

October 2014

Latest research from healthcare databases:

Title: Patient Safety: A Cultural Affair.

Citation: AORN Journal, 01 October 2014, vol./is. 100/4(355-357), 00012092

Author(s): Doreen Wagner, V.

Source: CINAHL

Title: The evolving literature on safety WalkRounds: emerging themes and practical messages.

Citation: BMJ Quality & Safety, 01 October 2014, vol./is. 23/10(789-800), 20445415

Author(s): Singer, Sara J., Tucker, Anita L.

Source: CINAHL

Full Text: Available from *Highwire Press* in BMJ Quality and Safety

---

Title: Exposure to Leadership WalkRounds in neonatal intensive care units is associated with a better patient safety culture and less caregiver burnout.

Citation: BMJ Quality & Safety, 01 October 2014, vol./is. 23/10(814-822), 20445415

Author(s): Sexton, J. Bryan, Sharek, Paul J., Thomas, Eric J., Gould, Jeffrey B., Nisbet, Courtney C., Amspoker, Amber B., Kowalkowski, Mark A., Schwendimann, Ren Profit, Jochen

Abstract: Background Leadership WalkRounds (WR) are widely used in healthcare organisations to improve patient safety. The relationship between WR and caregiver assessments of patient safety culture, and healthcare worker burnout is unknown. Methods This cross-sectional survey study evaluated the association between receiving feedback about actions taken as a result of WR and healthcare worker assessments of patient safety culture and burnout across 44 neonatal intensive care units (NICUs) actively participating in a structured delivery room management quality

improvement initiative. Results Of 3294 administered surveys, 2073 were returned for an overall response rate of 62.9%. More WR feedback was associated with better safety culture results and lower burnout rates in the NICUs. Participation in WR and receiving feedback about WR were less common in NICUs than in a benchmarking comparison of adult clinical areas. Conclusions WR are linked to patient safety and burnout. In NICUs, where they occurred more often, the workplace appears to be a better place to deliver and to receive care.

Source: CINAHL

Full Text: Available from *Highwire Press* in BMJ Quality and Safety

---

Title: 'I think we should just listen and get out': a qualitative exploration of views and experiences of Patient Safety Walkrounds.

Citation: BMJ Quality & Safety, 01 October 2014, vol./is. 23/10(823-829), 20445415

Author(s): Rotteau, Leahora, Shojania, Kaveh G., Webster, Fiona

Abstract: Objective This article is an exploration of views and experiences of Patient Safety Walkrounds, a widely recommended strategy for identifying patient safety problems and improving safety culture. Design and setting Qualitative analysis of semistructured, in-depth interviews with 11 senior leaders and 33 front-line staff at two major teaching hospitals with mature walkrounds programmes, collected as part of a larger mixed-methods evaluation. Results Despite differences in the structure of the two walkrounds programmes, senior leaders at both institutions reported attitudes and behaviours that contradict the stated goals and principles of walkrounds. Senior leaders tended to regard executive visibility as an end in itself and generally did not engage with staff concerns beyond the walkrounds encounter. Some senior leaders believed they understood patient safety issues better than front-line staff and even characterised staff concerns as 'stupid'. Senior leaders acknowledged that they often controlled the conversations, delimiting what counted as patient safety problems and sometimes even steered the conversations to predetermined topics. Some front-line staff made note of these contradictions in their interviews. Discussion/conclusions Our study found that walkrounds may inadvertently lead to counterproductive attitudes by senior leaders at odds with the recommended principles of walkrounds. The results demonstrate similar attitudes from senior leaders at two hospitals with quite different formats for walkrounds, suggesting that this pattern may exist elsewhere. Better preparation of senior leaders prior to the walkrounds may help to avoid the counter-productive attitudes and dynamics that we identified.

Source: CINAHL

Full Text: Available from *Highwire Press* in BMJ Quality and Safety

---

Title: Effectiveness and implementation of patient safety care.

Citation: Journal of Nursing Management, 01 October 2014, vol./is. 22/7(823-824), 09660429

Author(s): Severinsson, Elisabeth

Source: CINAHL

Title: Longer shifts are a threat to patient safety, Europe-wide survey shows.

Citation: Nursing Standard, 01 October 2014, vol./is. 29/5(13-13), 00296570

Author(s): Keogh, Kat

Abstract: Staff working overtime and 12-hour shifts are compromising patient safety and quality of care, a survey of 30,000 nurses reveals.

Source: CINAHL

Full Text: Available from *EBSCOhost* in Nursing Standard

Title: Safe administration of blood components.

Citation: Nursing Times, 17 September 2014, vol./is. 110/38(16-19), 09547762

Author(s): Hurrell, Katy

Source: CINAHL

Full Text: Available from *KS Local Holdings* in Nursing Times

---

Title: Patient safety still lagging: advocates call for national patient safety monitoring board.

Citation: JAMA: Journal of the American Medical Association, 03 September 2014, vol./is. 312/9(879-880), 00987484

Author(s): Kuehn, Bridget M

Source: CINAHL

Full Text: Available from *JAMA* in Rotherham FT Library & Knowledge Service

---

Title: Regular contact with colleagues could keep GPs and patients safer.

Citation: Guidelines in Practice, 01 September 2014, vol./is. 17/9(47-52), 14646420

Author(s): Merriman, Honor

Source: CINAHL

Title: Developing and testing a framework to measure and monitor safety in healthcare.

Citation: Clinical Risk, 01 May 2014, vol./is. 20/3(64-68), 13562622

Author(s): Illingworth, John

Abstract: The NHS excels at measuring incidences of past harm whether it is falls or hospital-acquired infections but research undertaken by Charles Vincent, Jane Carthey and Susan Burnett for the Health Foundation suggests past harm is only one element of what is needed to understand how safe care is. The researchers developed a framework to incorporate other necessary elements, such as anticipating and preparing for risks before they lead to harm to patients. In 2013, the Health Foundation road-tested this framework with staff in three NHS organisations and held a two-day summit with leaders from across the healthcare system to get feedback on its potential. This article presents the findings of this phase of work and sets it in the context of recent changes in the policy and regulatory landscape for patient safety in England. It concludes that the framework offers a great deal of potential for supporting organisations to understand the safety of their services. The framework could be most effective when used to identify the relative strengths and weaknesses of current safety measures, and when staff are given sufficient time, resource and support to consider the complex issues surfaced by the questions in the framework. This needs to be matched by a system of regulation which is aligned and mature, and an approach from NHS Trust Boards which welcomes information about the risks of its services.

Source: CINAHL

Full Text: Available from *EBSCOhost EJS* in Clinical Risk

Title: A standard of care: patient-safety advocates issue call for watchdog

Citation: Modern healthcare, June 2014, vol./is. 44/24(8-9), 0160-7480 (16 Jun 2014)

Author(s): Carlson J., Rice S.

Source: EMBASE

Full Text: Available from *EBSCOhost* in Modern Healthcare

Title: Safe and sound. Informed design approaches help to prevent patient harm

Citation: Health facilities management, June 2014, vol./is. 27/6(14-19), 0899-6210 (Jun 2014)

Author(s): Eagle A.

Source: EMBASE

Full Text: Available from *EBSCOhost* in Health Facilities Management

---

Title: Inter-professional training to enhance surgical safety: are we missing an opportunity?

Citation: British journal of hospital medicine (London, England : 2005), July 2014, vol./is. 75/7(414), 1750-8460 (Jul 2014)

Author(s): Khajuria A., Darzi A., Sevdalis N.

Source: EMBASE

Full Text: Available from *EBSCOhost* in British Journal of Hospital Medicine (17508460)

Title: The impact on patient safety on delays in retrieval of critically ill children to intensive care

Citation: Pediatric Critical Care Medicine, May 2014, vol./is. 15/4 SUPPL. 1(214), 1529-7535 (May 2014)

Author(s): Ray S., Yallop K., Walsh S.A., Ramnarayan P.

Abstract: Background and aims: The U.K. Paediatric Intensive Care Society (PICS) standard for retrieval of critically-ill children to intensive care is for the team to reach the child's bedside within three hours of the decision to retrieve. During times of increased demand this standard may not be met. In such instances, an acuity based triage process is used to prioritise retrieval. Aims: We hypothesised that the risk of patient adverse events increased with longer waiting times for the retrieval team. Methods: We undertook a case-control study using case-note review of children who waited for longer and less than 6 hours for a retrieval team, over a two year period. Adverse events that occurred during the stabilisation of the child, as defined by PICANET (Paediatric Intensive Care Audit Network), were identified. The need for informed consent was waived by the local audit department. Results: 49/2255 (2.2%) children waited for longer than 6 hours for a retrieval team.

There were 10 patient related adverse events prior to retrieval team arrival, and 11 after their arrival. In comparison, in 89 diagnosis and age matched controls who waited for less than 6 hours, there were 3 adverse events prior to retrieval team arrival and 8 following. For children waiting longer than 6 hours, the odds ratio of having an adverse event prior to retrieval team arrival is 6.1 (95%CI 1.6-23.0). Conclusions: Although retrievals are triaged according to acuity, waiting times longer than 6 hours can increase patient instability. Further evaluation is needed to validate this result, given the implications for service provision.

Source: EMBASE

Full Text: Available from *Springer ebooks NHS Pilot 2014 (NESLi2)* in Pediatric Critical Care Medicine

---

Title: Bridging the gap: Improving patient safety through targeted in-situ simulation training on paediatric intensive care unit.

Citation: Pediatric Critical Care Medicine, May 2014, vol./is. 15/4 SUPPL. 1(212), 1529-7535 (May 2014)

Author(s): Nayak P.P., Kidd N., Osborne-Ricketts B., Martin J., Heward Y.

Abstract: Background and aims: Improving patient safety is important on PICU. Simulation education has generally focused on management of clinical diagnoses and is syllabus driven. There is a need to bridge the gap between the two streams. Aims: To reduce high-risk events on PICU over time following the introduction of a 'risk-targetted' simulation training strategy. Methods: A 31-bedded tertiary PICU with 1500 admissions/year. All adverse incidents are collated (specific forms for incidents involving medications, accidental extubations, buzzer pulls and extravasations) and analysed by the PICU Safety Group. The PICU Simulation Team delivers in-situ simulation training for the multidisciplinary PICU staff weekly using hi-fidelity manikins. The 'Simulation Group' (efferent) and the 'Safety Group' (afferent) discuss priorities for the unit and the lessons learnt are implemented during scenarios. This may be utilisation of a 'care bundle' or activation of a 'clinical pathway'. Practical problems are fed back to the Safety Group to close the loop. Results: Examples of scenarios run include accidental extubations, delay in sepsis recognition/antibiotics prescription, ischaemic limb injury due to indwelling arterial line. Scenarios are re-run back to back if the team doesn't achieve expected outcomes. The anonymous feedback forms by the participants of the scenarios have shown they value this targeted training. The trend of 'incident severity' is on the decline on our PICU but long term monitoring will continue to identify any re-emerging or fresh trends. Conclusions: 'Targeted' simulation training is an effective training tool to enhance the safety culture on PICU. 'PICU Safety' and 'Simulation Groups' should develop a symbiotic relationship for this to succeed.

Source: EMBASE

TRFT Library & Knowledge Service

A library & knowledge service for all NHS staff in Rotherham

Full Text: Available from *Springer ebooks NHS Pilot 2014 (NESLi2)* in Pediatric Critical Care Medicine

---

Title: How can information technology improve patient safety in the paediatric intensive care unit

Citation: Pediatric Critical Care Medicine, May 2014, vol./is. 15/4 SUPPL. 1(210), 1529-7535 (May 2014)

Author(s): Mencigar D., Rajkovic V., Rajkovic U., Princic B., Sustersic O.

Abstract: Background and aims: In the intensive care unit (ICU) the level of critical care is intense and the amount of documentation is enormous. Failure to document any aspects, may threaten the continuity of care, patient safety and safety of health team members. With new clinical information system (CIS) at the University Children's Hospital Ljubljana, called Think!Med ClinicalTM, documenting became much easier job. Aims: The healthcare e-documentation model can further contribute to patient data management in relation to medical devices connectivity. Due to barcode identification and management of medication lists ICU professionals avoid medication errors by drug prescribing and drug application. Gathering much more structured clinical data provides a platform for clinical decision support. Methods: The proposed model is based on literature review and our clinical experiences with the e-documentation. Over 20 different medical devices were connected as a prototype in the ICU. The prototype was implemented and tested in clinical practice and critically evaluated. Results: The implementation project was completed in record time and enabled the hospital to fulfill their goal of taking a major step towards paperless operations. Conclusions: Due to the new e-documentation model, work organization and communication at the Paediatric ICU, which is part of the Department for Paediatric Surgery and Intensive Care, were completely changed. Information technology offers opportunities for data processing, decision-making and research. A new solution leads to improvement of patient documentation, enhancing the quality and effectiveness of the health care, increasing patient safety and time saving.

Source: EMBASE

Full Text: Available from *Springer ebooks NHS Pilot 2014 (NESLi2)* in Pediatric Critical Care Medicine

---

Title: Improvement in reporting of safety incidents revealed

Citation: Nursing management (Harrow, London, England : 1994), June 2014, vol./is. 21/3(7), 1354-5760 (Jun 2014)

Abstract: Staff in England are improving how they recognise and report patient safety incidents, according to figures from the National Reporting and Learning System (NRLS). The statistics cover the

period between April 1 and September 30 last year, and show a 9% increase in the number of incidents reported compared to the same period in the previous year.

Source: EMBASE

Full Text: Available from *EBSCOhost* in Nursing Management - UK

Title: Doing your best as a health professional to keep patients safe

Citation: British journal of nursing (Mark Allen Publishing), June 2014, vol./is. 23/12(674-675), 0966-0461 (2014 Jun 26-Jul 9)

Author(s): Tingle J.

Source: EMBASE

Full Text: Available from *EBSCOhost* in British Journal of Nursing

---

Title: Good communication and the safe healthcare environment

Citation: British journal of nursing (Mark Allen Publishing), July 2014, vol./is. 23/13(754-755), 0966-0461 (2014 Jul 10-23)

Author(s): Tingle J.

Source: EMBASE

Full Text: Available from *EBSCOhost* in British Journal of Nursing

---

Title: Validation of a teamwork perceptions measure to increase patient safety

Citation: BMJ Quality and Safety, September 2014, vol./is. 23/9(718-726), 2044-5415 (September 2014)

Author(s): Keebler J.R., Dietz A.S., Lazzara E.H., Benishek L.E., Almeida S.A., Toor P.A., King H.B., Salas

Abstract: Background: TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) is a team-training intervention which shows promise in aiding the mitigation of medical errors. This article examines the construct validity of the TeamSTEPPS Teamwork Perceptions Questionnaire (T-TPQ), a self-report survey that examines multiple dimensions of perceptions of teamwork within healthcare settings. Method: Using survey-based methods, 1700 multidisciplinary

healthcare professionals and support staff were measured on their perceptions of teamwork. Confirmatory factor analysis was conducted to examine the relationship between the five TeamSTEPPS dimensions: Leadership, Mutual Support, Situation Monitoring, Communication, and Team Structure. Results: The analysis indicated that the T-TPQ measure is more reliable than previously thought (Cronbach's alpha=0.978). Further, our final tested model showed a good fit with the data (x2 (df) 3601.27 (546), p<0.0001, Tucker-Lewis Index (TLI)=0.942, Comparative fit index (CFI)=0.947, root mean square error of approximation (RMSEA)=0.057), indicating that the measure appears to have construct validity. Further, all dimensions correlated with one another, but were shown to be independent constructs. Conclusions: The T-TPQ is a construct-valid instrument for measuring perceptions of teamwork. This has beneficial implications for patient safety and future research that studies medical teamwork.

Source: EMBASE

Full Text: Available from *Highwire Press* in BMJ Quality and Safety

---

Title: Improving safety and quality of care with enhanced teamwork through operating room briefings

Citation: JAMA Surgery, August 2014, vol./is. 149/8(863-868), 2168-6254 (August 2014)

Author(s): Hicks C.W., Rosen M., Hobson D.B., Ko C., Wick E.C.

Abstract: OBJECTIVES To describe the current state of the science for operating room (OR) briefings and debriefings, including an overview of key definitions, a review of the evidence of effectiveness, and a summary of our experiences as part of a comprehensive unit-based safety program. OVERVIEW Use of preoperative briefings has been shown to improve team communication, decrease disruptions to surgical workflow, improve compliance with antibiotic and deep vein thrombosis prophylaxis, and improve overall perceptions about the safety climate in the OR. Studies have demonstrated that an effective briefing can be performed in less than 2 minutes and reduce delays by more than 80%. Effective implementation involves changing workflows and expectations of interaction among OR team members, including participation from leaders at all levels. Briefings and debriefings are a strategy for revealing defects and facilitating adaptive change in the OR. CONCLUSIONS AND RELEVANCE Briefings and debriefings are a good method for improving teamwork and communication in the OR. Effective implementation may be associated with improved patient outcomes. Commitment by the participating providers is essential for effective briefings, which include discussion of relevant information pertaining to the procedure. Copyright 2014 American Medical Association. All rights reserved.

Source: EMBASE

TRFT Library & Knowledge Service

A library & knowledge service for all NHS staff in Rotherham

Title: Recognizing fatigue as a safety hazard.

Citation: Hospital Peer Review, August 2014, vol./is. 39/8(89-90), 0149-2632;0149-2632 (2014 Aug)

Publication Type: Journal Article

Source: MEDLINE

Online resources:

NHS Improving Quality Patient Safety Programme
http://www.nhsiq.nhs.uk/improvement-programmes/patient-safety.aspx

Patient Safety (NHS England Website)
http://www.england.nhs.uk/ourwork/patientsafety/

Patient Safety (Health Foundation Website)
http://www.health.org.uk/areas-of-work/topics/patient-safety/

Patient safety resource centre
http://patientsafety.health.org.uk/

National Patient Safety Agency
http://www.npsa.nhs.uk/

Reporting Patient Safety issues
http://www.nrls.npsa.nhs.uk/

Patient Safety 1st
http://www.patientsafetyfirst.nhs.uk/content.aspx?path=/

National Patient Safety Alerting System
http://www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/

An introduction to the NHS England National Patient Safety Alerting System
http://www.england.nhs.uk/wp-content/uploads/2014/01/npsas-guide.pdf